Brighton CHC

THE TRANSFER FROM HOSPITAL TO COMMUNITY

A SURVEY OF THE DIFFICULTIES ENCOUNTERED IN THE DISCHARGE AND AFTER CARE OF ELDERLY PATIENTS ADMITTED TO ACUTE HOSPITALS WITH SOME EXAMPLES OF GOOD PRACTICE

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A. INTRODUCTION

1. Cause for Concern

Brighton Community Health Council (C.H.C.) first began to make local enquiries into this transfer process in 1984 because we were concerned that the increasing throughput of hospital patients might be having adverse effects on continuity of care, particularly with respect to those patients likely to experience a protracted period of recovery. It is well known that elderly people - in part because they are prone to multiple pathologies- often require longer to convalesce than those who are younger [1] and are therefore likely to need ongoing medical and social support after discharge from hospital. In Brighton Health District, we have a high proportion of the population elderly (22.5%) and we therefore decided to look at the planning for discharge and provision of after-care received by elderly patients at our major acute hospital - the Royal Sussex County, in Brighton.

With the help of Brighton Health Authority we were able to interview 128 patients aged 65 years or over, in their own homes some two or three week after they had left hospital [2]. These patients included both men and women, differed in age from 65-92 years and had been discharged from 19 different hospital wards, thus representing a varied cross section of the elderly patients treated in the hospital. No professional assessment was included in the study but to the interviewers' untrained eye 77% appeared

to be completely lucid at the time of the interview and a mere 6 individuals (5%) sufficiently confused to suggest a serious mental condition. Equally diverse were their home circumstances - 43% lived alone, 30% with another elderly relative only. While 30% claimed at least one relative living within one mile, 23% denied having any relatives within ten miles.

We were relieved to discover relatively few patients who appeared to have slipped through the net of welfare service, to return to empty houses or to be left totally without needed support. As many as 2/3rds of the patients to whom we talked, claimed to be satisfied with the preparations for their discharge and subsequent after-care, but our findings did suggest that in spite of the good intentions of staff within the hospital and within the community, there remained cause for concern. A surprising 51% felt that there had not been anyone within the hospital with whom they could discuss any anxieties concerning their discharge and after-care, 35% claimed that they had been given less than 24 hours notice of discharge and several experienced long waits for ambulance transport home. Weekend discharges were not uncommon - 39% of our sample were discharged Friday, Saturday or Sunday. While only 11% received no visitors during their first 48 hours at home, professional support of any kind was very limited - 18% seeing a GP, 16% a District Nurse and a mere 6% either a Social Worker or a Health Visitor. There was heavy reliance on informal support from friends and more especially relations but in several instances it appeared that

unrealistic expectations were being entertained concerning the capacity of elderly relatives to cope. Several patients expressed a desire for forms of support they were not receiving although they may well have rejected other offers perceived as inappropriate. More Home Help support and visits from GP and/or District Nurse were most often specified. Sometimes in the case of the former, assistance arrived several days late, while with regard to the GP service we discovered an element of confused expectations - many elderly patients expecting a routine visit which their GP did not anticipate providing.

Our concern as a C.H.C. with standards of service locally, has been reinforced by a small follow up study undertaken a year later [3] which indicated that the sub sample of 33 patients from our original 128 patients who had subsequently been re-admitted to one of the District's hospitals, had originally been more inclined to claim that they did not feel ready to leave hospital on discharge and that they did not receive adequate support when they got home. This was a very crude follow up exercise, taking no account of the reasons for subsequent re-admission but it did suggest the possibility that an ill-prepared discharge might lead to preventable re-admission - a situation neither in the best interest of the patient nor of the Health Authority who foots the bill. This hypothesis has also been recently raised elsewhere and might perhaps warrant further investigation [4].

Indeed as we put together our report we came to realise that many of the problems we were encountering in Brighton had already

been found to exist in other Health Authorities. The work of the Continuing Care Project in Birmingham provided extensive documentation of similar difficulties [5]. We also found in the literature, some suggestions for improvement which we were able to incorporate in recommendations to our own Health Authority, East Sussex County Council and East Sussex Family Practitioner Committee with which we concluded our report [6].

From the beginning we had seen our research as instrumental rather than as an end in itself. It was specifically designed to provide us with useful information on the nature and extent of any problems so that we would be in a better position to press for relevant improvements to the services currently provided. We had tried as far as possible to work with service providers in the design and execution of the survey in order to build up an interest in it and a commitment to take action upon it. Publication therefore in December 1985 was immediately followed by a seminar at our local post-graduate medical centre to which representatives from all the professions and voluntary organisations involved both in the hospital and in the community were invited. This led in turn to a series of working parties and ad hoc meetings with individual agencies and groups of workers, at which our recommendations were discussed and a number of new initiatives considered. This process is still continuing. We have been fortunate that a visit by a team from the Health Advisory Service to Brighton to review services for elderly people took place shortly after our report was published and has

concentrated attention within our District on this client group over the last twelve months. Brighton Health Authority has now issued a draft version of a formal discharge policy [7] and our Social Service Department plan a short term Home Line Scheme to make Home Help support freely and quickly available on discharge to those deemed to need it. Age Concern has developed a new Crisis Intervention Service and the voluntary organisations locally have got together to produce a leaflet outlining the potentially helpful facilities in the voluntary sector and offering a single point of contact for them.

2. Why this Study?

Despite the hard work of members and staff in Brighton C.H.C. we remain conscious of our limited resources. We have investigated the situation in our own back yard and drawn upon a growing body of literature to support our conclusions and recommendations, but we felt that consultations with colleagues in other C.H.C.s would be very helpful, both as regards exploring the nature of the problem and hopefully in suggesting ways to overcome current difficulties. Of course situations vary across the country in terms of demographic structure, existing service provision both within the National Health Service and within Social Service Departments and the extent of voluntary and informal care, to mention only a few of the most obvious variables, but providing due regard is paid to differing contexts, we felt we had much to learn.

In May 1986 therefore we presented our research findings to the South East Thames Regional Association of C.H.C.s at Guys Hospital and went on in July to lead a workshop at the Association of Community Health Councils of England and Wales (ACHCEW) annual conference in Canterbury. At the workshop so much time was spent discussing the difficulties many of us faced with regard to the discharge and after-care of elderly patients from acute hospitals that we were left with insufficient time to explore the solutions that several Districts were apparently trying to implement. In order therefore to get a more detailed and comprehensive picture of the problem and more particularly to learn of the variety of local initiatives already under-taken to improve the discharge process and/or immediate post discharge after-care, we decided to seek the good offices or ACHCEW to help us circulate a postal questionnaire to members. As we suggested in our response to ACHCEW's consultation document on the role of C.H.C.s [8] we in Brighton feel that a national organisation can help facilitate members' research and help to consolidate our individual efforts.

References

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